

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC #2 rec'd 9/12/11

PRINTED: 09/07/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 09/06/2011
NAME OF PROVIDER OR SUPPLIER  IMPERIAL GARDENS HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE MADISON, TN 37115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  A revisit was completed at Imperial Gardens Health and Rehabilitation Center on September 6, 2011, following acceptance of the Allegation of Compliance to remove the Immediate Jeopardy at F333 Scope and Severity level "J". The revisit revealed the corrective actions implemented August 30, 2011, removed the Immediate Jeopardy at F333, but non-compliance continues at a "D" as evidenced by the findings at F333. The "G" level citation at F323 and the "D" level citations at F157 and F281 remain outstanding. The facility is required to submit a plan of correction for all outstanding tags.	{F 000}	F 000 Without admitting or denying the citations rendered, Imperial Gardens Health and Rehabilitation alleges it will be in compliance with all deficiencies on September 12, 2011.	9/12/11	
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	{F 157}	F 157 Imperial Gardens will ensure appropriate parties are notified when there is a significant change in the resident's condition, a change in treatment, or a decision to transfer or discharge a resident.  Resident # 11's family was notified on 8/9/2011 of an elevated PT/INR when the first and when the second lab results were obtained by the nurse on duty making the discovery. The on-call Nurse Practitioner was also notified as well as the Attending Physician by the nurse on duty making the discovery. Additionally, the Attending Physician was notified that same day of the medication error by the nurse on duty making the discovery. The family was also notified that the resident was being transferred to the hospital due to the elevated PT/INR by the nurse on duty when the resident was transferred.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 157}	<p>Continued From page 1</p> <p>the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the family of a significant medication error for one resident (#11) of thirty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #11 was admitted to the facility on July 11, 2011, with diagnoses including Diabetes, Cerebral Artery Occlusion, Cerebral Infarction, Chronic Anticoagulation, Hyperlipidemia, and Diabetic Retinopathy.</p> <p>Review of a Physician's Order dated August 5, 2011, revealed, "(Coumadin) Warfarin Sodium 4 mg (milligrams) Tablet (medication that thins the blood) by mouth at bedtime 9:00 p.m. Sat, Sun, Tues, and Thurs (Saturday, Sunday, Tuesday and Thursday)...(Coumadin) Warfarin Sodium</p>	{F 157}	<p>Attempts to communicate with the family regarding the medication error failed due to the family canceling a meeting set up with them on 8/9/2011; not answering the phone on 8/11/2011; and hanging up on the Administrator and Social Worker during a conversation on 8/11/2011. On this last attempt the family stated they did not want to talk with Imperial Gardens anymore about anything just prior to hanging up the phone and ending the conversation.</p> <p>Resident # 11 is no longer at the facility.</p> <p>Residents with any change in condition, medication error, or discharge/transfer to a hospital have the potential to be effected.</p> <p>Beginning on August 16, 2011 all team leader nurses were in-serviced by IDON, an LPN and Nurse Educator regarding notification to appropriate parties when a resident has a change in condition. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on notification to appropriate parties when a resident has a change in condition prior to working on the units by the Nurse Educator or designee.</p>		

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(F 157)	Continued From page 2  Medical record review of the facility's investigation dated August 11, 2011, revealed, "...Order = (equals) Coumadin 3 mg po (by mouth) M, W, F (Monday, Wednesday, and Friday). Coumadin 4 mg Sun, Tues, Thurs, Sat (Sunday, Tuesday, Thursday, and Saturday). On 8/6/11, 8/7/11, and 8/8/11, received Coumadin 7 mg... The LPNs (Licensed Practical Nurses) did not read the orders, they just looked at the empty spaces on the MAR (Medication Administration Record), gave the med. (medication) and went on..."  Medical record review revealed no documentation the family was notified of the significant medication errors (resident received seven milligrams of coumadin for three consecutive days).  Interview with the Interim DON (Director of Nursing) on August 17, 2011, at 2:10 p.m., in the conference room, confirmed the facility failed to notify the family of the resident receiving 7 mg of Coumadin for three days instead of Coumadin 3 mg alternating with Coumadin 4 mg.	(F 157)	The IDON or designee reviews the 24 hour report daily. This report identifies residents who have a change in condition or treatment based on physician orders. The IDON or designee will review daily to assure appropriate parties are notified in a timely manner when such notification is warranted. The 24 hour report is automatically generated from the Electronic Charting System (ECS)  Additionally, the IDON or designee reviews changes in resident condition or treatment in a stand up meeting with the Team Leaders and other members of the IDT (i.e. therapy, social service, wound nurse). These daily meetings discuss residents with changes in condition or treatment. If an appropriate party has not been informed of the change in condition or treatment, the IDON, Team Leader Nurse or designee follows up with the appropriate parties immediately.		
(F 281) SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow Physician's Orders for the administration of a medication for one (#31) of thirty-one residents reviewed.	(F 281)	The IDON or designee tracks and trends these results and reviews the overall effectiveness of the system. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meeting held monthly but not less than quarterly.		

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{F 281}	<p>Continued From page 3</p> <p>The findings included:</p> <p>Resident #31 was admitted to the facility on May 11, 2011, and re-admitted on June 30, 2011, with diagnoses including Hypertension, Dementia, and Myocardial Infarction.</p> <p>Medical record review of a Physician's Re-admission Orders dated June 30, 2011, revealed, "Senna 15 mg (milligrams) Tablet by mouth bid (twice a day), 0800 (8:00 a.m.), 2000 (8:00 p.m.) for constipation."</p> <p>Medical record review of the Physician's Recapitulation Orders for July and August, 2011, revealed, "Senna 15 mg Tablet by mouth bid. 8:00 a.m., 8:00 p.m. (Hold for diarrhea): For Constipation."</p> <p>Medical record review of the Medication Administration Record dated July, 2 2011, through August 18, 2011, revealed, "Senna 15 mg Tablet by mouth bid. 8:00 a.m., 8:00 p.m..."</p> <p>Observation of the medication cart on August 18, 2011, at 10:45 a.m., with the medication nurse (#7) on the west wing, revealed Senna 8.6 mg tablets in the cart.</p> <p>Interview with the medication nurse (#7) on the west wing on August 18, 2011, at 10:45 a.m., in the hall, revealed, "I have always given two tablets of Senna 8.6 mg (to resident #31)."</p> <p>Interview with the Restorative Nurse Assistant on August 18, 2011, at 11:00 a.m., on the west wing, confirmed, "The resident received Senna 8.6 mg</p>	{F 281}	<p>F 281</p> <p>Medications will be given according to Physicians' Orders and professional standards of care.</p> <p>A physicians' clarification order was written on August 19, 2011 regarding the Senna for resident # 31 to receive 2 Senna 8.6 mg tablets. The resident continues to receive the correct dose of Senna.</p> <p>Residents receiving medications have the ability to be effected. On August 17-19, 2011 the IDON lead a team comprised of LPNs, RNs, MDS RN, MDS LPNs to complete a medication match-back process to insure no other residents were affected.</p> <p>On August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding appropriate medication passage including transcription of physician orders. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on medication pass prior to working on the units by the Nurse Educator, IDON or designee.</p> <p>Additionally, one-on-one "return demonstration" for accurate order entry was conducted with licensed staff on 8/28/2011 through 8/30/2011 by clinical resources outside the facility.</p>		

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{F 281}	Continued From page 4 bid, but on June 30, 2011, the admission nurse entered Senna 15 mg bid into the computer (ECS-Electronic Computer System)."  Interview with the MDS (Minimum Data Set) Nurse #1 on August 20, 2011, at 9:10 a.m., in the conference room, confirmed, "I called the Physician to validate the order for Senna 8.6 mg bid on June 30, 2011, but I failed to write the order or put it in the computer.	{F 281}	are noted they will be corrected by the Nurse Educator, IDON or designee immediately to assure the resident does not get the incorrect medication. A medication error report will be initiated by the person conducting the audit and the IDON or designee will be notified.  The results of the these audits are given to the IDON or designee. The IDON or designee tracks and trends these results and reviews the overall effectiveness of the system and reviews the outcomes. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.		
{F 323} SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility provided documentation (investigation), observation, facility policy review, and interview, the facility failed to provide the assistance of a two-person transfer or the use of a mechanical lift during a transfer for one resident (#1) of thirty-one residents reviewed. The facility's failure to provide adequate assistance for resident #1 resulted in a fractured tibia and fibula (Actual Harm).	{F 323}	F 323 Residents will receive adequate supervision and assistance devices to prevent accidents.  Resident # 1 is transferred to bed according to her plan of care.  Prior to the incident the nurse aide involved had been instructed on proper transfers and lifts, gait belts, and proper body mechanics at various in-services provided by the facility.		

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{F 323}	<p>Continued From page 5</p> <p>The finds included:</p> <p>Resident #1 was admitted to the facility on October 9, 2009, with diagnoses including Genile Dementia, Hypertension, Osteopenia, Cardiovascular Accident, and Dysphagia.</p> <p>Medical record review of the MDS (Minimum Data Set) dated July 12, 2011, revealed the resident required total assistance with transfers and all activities of daily living.</p> <p>Review of the current care plan dated May 14, 2011, revealed, "... Use gait belt when assisting with transfers..."</p> <p>Review of the facility's CNT (Certified Nurse Technician) Care Card (card that instructs the CNTs on the care of the resident) dated July 30, 2011, revealed, "...Requires 2 people for transfers and for bed mobility and may use lift..." Further review revealed the CNT Care Card did not match the current plan dated May 14, 2011.</p> <p>Review of the facility's investigation dated July 31, 2011, revealed, "Current intervention: transfer assist x (times) 2/mechanical lift (transfer with the assistance of two or use of a mechanical lift)..."</p> <p>Medical record review of a nursing note dated July 31, 2011, at 8:19 a.m., revealed, "INCIDENT TYPE: other: left foot/leg caught in side rail during transfer. DATE OF INCIDENT: 07/30/2011. TIME OF INCIDENT: 10:30 p.m....night shift. Description of Incident: After being transferred to bed, left leg became wedged between side rail, which was down, and bed. CNT described</p>	{F 323}	<p>The nurse aide involved in the incident was immediately suspended pending the outcome of the investigation and was later terminated.</p> <p>All residents being transferred are at risk to be effected.</p> <p>All nurses' aides were trained by the Nurse Educator or designee August 1, 2011 through August 11, 2011 regarding the lifting policy, resident care cards, resident care plans and transfers. New nurse aides including any agency aides will receive training on lifting policy, resident care cards, resident care plans and transfers prior to caring for residents by the Nurse Educator or designee.</p> <p>Resident Care Cards are generated automatically from the resident Care Plans in ECS. Nurse aides will check the resident Care Cards prior to transferring residents to assure they know how the resident is to be transferred. Nurse aides are monitored by the Nurse Educator, Team Leaders or their designee for proper transfer techniques including using the appropriate number of people and equipment. These audits will be completed weekly X 3 weeks and then monthly X 3 months.</p> <p>The results of the these audits are given to the IDON or designee. The IDON or designee tracks and trends these results and reviews the overall effectiveness of the system and reviews the outcomes. The results of this tracking and trending are presented to the QI Team composed of the</p>		

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{F 323}	<p>Continued From page 6</p> <p>hearing a "POP" and then the resident's leg was between the rail and the bed. This resulted in a 3.5 inch x 1.5 inch raised area to left shin. No bruising. Swelling present...pain and swelling to left lower anterior leg...FIRST AID: emergency room: POSSIBLE CAUSE...STAFF INVOLVED..."</p> <p>Medical record review of a Physician's Order dated July 30, 2011, at 11:15 p.m., revealed, "transfer to...(local hospital)..."</p> <p>Medical record review of a Radiology Report dated July 31, 2011, revealed, "...On the left there is an oblique fracture of the distal third of the tibia with fracture fragments in near anatomic alignment...there is also a fracture of the distal fibular diaphysis...There is severe extensive Osteopenia...The fibular fracture may be old, although this is not certain."</p> <p>Medical record review of a Hospital Physician's History and Physical dated July 31, 2011, revealed, "...The patient has mild tenderness to palpation about the left mid shaft tibia. (Resident's) compartments are very soft and compressible...(resident) has no pain..."</p> <p>Medical record review of the hospital discharge instructions dated July 31, 2011, revealed, "...This type of injury often occurs when the ankle is severely twisted causing tearing of the ankle ligaments and also a break in the bone that the ligaments are holding together..."</p> <p>Medical record review of a nursing note dated August 1, 2011, at 10:29 a.m., revealed, "Returned from...(local hospital) ER (Emergency</p>	{F 323}	<p>Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.</p>		

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{F 323}	<p>Continued From page 7</p> <p>Room). Splint to left leg. Ace wrap from foot to mid thigh..."</p> <p>Review of the facility's investigation dated August 1, 2011, revealed, "Resident was being transferred from the shower chair to the bed when the left leg became entangled in the side rails. The side rails were in the low position. The CNT reported hearing a sound when she lowered (resident) onto the bed. The RN (Registered Nurse) was immediately notified and the resident was transferred to...(local hospital) where it was determined that...(resident) had fractures of the distal one-third of the tibia and fibula...(resident) was returned to the facility the following morning..."</p> <p>Review of the facility's documentation dated July 31, 2011, of an interview conducted by a RN (Registered Nurse) with the CNT that transferred the resident on July 20, 2011, revealed, "... (RN) asked (CNT) if CNT was aware of how many staff were supposed to transfer the (resident)...Ask why (CNT) attempted the transfer alone and (CNT) stated, "(Resident) was in a good mood and had been cooperative and everyone else was busy and (CNT) thought (CNT) could do it alone..."</p> <p>Review of the facility's investigation dated July 31, 2011, revealed, "(The CNT who transferred the resident) reported to be aware of the transfer status of the resident but made the decision to transfer the resident independently....(CNT) also reported did not use the gait belt which is also facility policy for use during transfers."</p>	{F 323}			

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{F 323}	<p>Continued From page 8</p> <p>Observation on August 15, 2011, at 8:30 a.m., revealed the resident lying in bed, asleep. Continued observation revealed a cast to the left lower leg.</p> <p>Review of the facility's policy for Transfers revealed, "It is the policy of this facility that a gait belt must be used when any resident is being ambulated. The gait belt must be applied before the resident stands."</p> <p>Interview with the Registered Nurse (#4) (who was working on the East Hall on July 31, 2011) on August 15, 2011, at 5:00 p.m., by phone, revealed, "The CNT called me to the room on July 30, 2011, about 10:00 p.m., and stated when (CNT) stood and pivoted the resident, (CNT) heard a popping sound. I examined the resident and sent (resident) to the Emergency Room. I asked the CNT why (CNT) attempted to transfer the resident, knowing it required two people. The CNT stated, "I didn't have any one to help me." I told CNT that (CNT) had not called for any help."</p> <p>Interview with the Administrator on August 15, 2011, at 1:00 p.m., in the conference room, confirmed the CNT failed to transfer the resident with the assistance of two people or the use of a mechanical lift, resulting in a fracture of the tibia and fibula (Actual Harm).</p> <p>C/O 28495</p>	{F 323}	<p>F 333</p> <p>Resident # 11 was transferred to the acute care hospital on 8-9-2011 by the registered nurse(RN) on duty upon the awareness of an elevated PT/INR level of 9.2. The Nurse Practitioner was notified. The RN on duty then reviewed Resident # 11's Medication Administration Record (MAR) and found that the resident had received three incorrect doses of Coumadin over the previous three days. The RN on duty immediately notified the on-call Nurse Practitioner, the attending physician and the Interim IDON (IDON) and was instructed by the IDON on to immediately initiate the investigation of the error that night.</p>		
(F 333) SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	{F 333}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 09/06/2011
NAME OF PROVIDER OR SUPPLIER  IMPERIAL GARDENS HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE MADISON, TN 37115		
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{F 333}	<p>Continued From page 9</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on survey results dated August 20, 2011, the facility failed to prevent a significant med error resulting in a critical PT/INR (Protime/International Normalization Ratio-lab test used to determine therapeutic levels for blood thinning medications) and hospitalization for one (#11) of fourteen residents receiving anticoagulation medication.</p> <p>The facility provided an acceptable Credible Allegation of Compliance with a compliance date of August 30, 2011. A revisit completed on September 6, 2011, revealed the corrective actions implemented August 30, 2011, removed the Immediate Jeopardy at F333, but non-compliance continues at a "D" level.</p> <p>Validation of the Credible Allegation of Compliance was accomplished through medical record review and interview with licensed nurses. The facility provided evidence of inservice and training records for all nursing staff related to the Medication Pass Exception Report, verification of admission/readmission orders during regular hours with two licensed nurses, verification of admission/readmission orders after 5:00 p.m. or during weekends, entering physician orders into the Electronic Charting System, Electronic Charting System Reference Cards, and Medication Administration. Included in the validation was review of facility tools used to</p>	{F 333}	<p>The IDON continued the investigation on 8-10-2011 by reviewing all residents on Coumadin therapy and the process of alternating patterns when writing Physician's orders. Alternating patterns means medications ordered to be administered on different days and/or medication doses to be given at different times. (i.e. Coumadin 3mg Monday, Wednesday, Friday and/or 4 mg Saturday, Sunday, Tuesday, Thursday). The findings of the facility investigation were reported to the Administrator and the Quality Improvement Coordinator (QIC) on August 10, 2011. The nurse who transcribed the physician order failed to use the appropriate order structure. Therefore, the alternating doses of the medication were not correctly sent to the MAR.</p> <p>The Registered Nurse who transcribed the physician order on 8-6-2011 received a written performance correction notice by the IDON on 8-11-2011 for failing to ensure the physician order was clearly transcribed into the Electronic Charting System (ECS). The IDON gave immediate education/training on 8-11-2011 regarding the proper procedure for entering physician orders into the Electronic Charting System (ECS) and then referring back to the MAR to</p>		

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(F 333)	<p>Continued From page 10</p> <p>document ongoing monitoring of verification of medication orders, accuracy of transcription of Physician orders to the Medication Administration Records and accuracy of the medication administration.</p> <p>Interview with seven licensed nurses on all units confirmed the licensed nurses had been inserviced on Coumadin orders and administration, admission and readmission order verification process, and had completed competencies for medication administration and entering Physician orders into the Electronic Charting System.</p> <p>Review of ten resident's (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10) physician orders and Medication Administration Records revealed the orders were entered correctly into the Electronic Charting Systems and were confirmed by two nurses. Observation of a Medication Pass on September 6, 2011, from 8:00 p.m.-9:00 p.m. of three resident's (#4, 5, 6) confirmed accurate administration of Coumadin and other medications.</p> <p>The facility remains out of compliance until it provides an acceptable plan of correction to include the continued monitoring to ensure the deficient practice does not reoccur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.</p>	(F 333)	<p>review and assure that it entered correctly. The two LPN's involved in the incident both received a written counseling on 8-11-2011 by the Registered Nurse for making a medication error involving Coumadin. The Registered Nurse gave immediate education/training on 8-11-2011 to the two LPN's involved regarding the five rights of administering medication thoroughly reading the physician orders and clarifying the order if there are questions prior to giving medications. The resident is no longer at this facility.</p> <p>Residents receiving medications have the potential to be affected by this practice, including, but not limited to, residents who have daily coumadin orders.</p> <p>Beginning on August 10, 2011 the physicians' orders in the residents' medical records were reviewed facility wide by the IDON and Licensed Practical Nurse (LPN) to assure that no other transcription errors related to Coumadin therapy had occurred. This "match back" process was conducted by a Licensed Practical Nurse (LPN) and the IDON. This process checked the physician orders in the electronic charting system (ECS) and matched them to the Medication Administration Record (MAR) focusing on</p>		

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{F 333}			{F 333}	<p>transcription errors. No other discrepancies were found.</p> <p>Beginning August 17, 2011 as part of ongoing quality improvement this process was repeated facility wide by MDS RN, MDS LPN, Staff RNs, Staff LPNs, LPN Unit Clerk, LPN Admission Nurse, LPN Medication Managers and Contract LPN lead by the IDON. This team audited physician orders, MARs and medications for all residents. The process checked the written physician orders on the medical record against the physician orders in the electronic charting system (ECS). Then, the physician orders were matched to the MAR and checked against the medications available in the medication carts. The only discrepancy noted was for one resident and one medication that had a start/stop date with the start date starting one day late. The physician was notified by the LPN conducting the audit and the physician extended the period of time for the medication for one day. This audit process was completed on August 19, 2011.</p> <p>The 24 hour report automatically pulls all new physician medication orders for the previous day to the 24 hour report. This 24 hour report is utilized to identify all new physician medication</p>	

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{F 333}			{F 333}	<p>orders written. All new physicians' medication orders entered by the licensed nurse are reviewed daily for appropriate format in the ECS by the IDON, or designee. This review is completed within 24 hours of any newly transcribed medication order. This includes the name of the drug, the dosage, the route, the frequency, the time and the reason (diagnosis) for the medication. Any errors or inconsistencies in the format of the medication order are immediately corrected by the IDON or designee.</p> <p>On January 7, 2011 the process for a Medication Pass Exception Report was initiated. This Medication Pass Exception Report identifies any resident whose medications were omitted and the reason for such. The Medication Pass Exception Report is automatically generated from the ECS and is printed after each medication pass by the RN/LPN Medication Nurse. This report is reviewed with the RN Team Leader and RN/LPN Medication Nurse at the end of each shift. Additionally, it is reviewed daily (within 24 hours of completion) by the IDON or designee. The reason for any medication omitted is written on this report and in the nurses' notes. If an error is detected, the Team Leader Nurse immediately, at the time of</p>	

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{F 333}			{F 333}	<p>discovery, notifies the IDON and the attending physician either in person or by a telephone call. The error is corrected/resolved by the Team Leader Nurse and the responsible party/Power of Attorney is notified of the incident. A medication error report is completed with the nurse who made the error for the purpose of ongoing quality improvement, and personal education and training. Then, the Exception Report is signed by the medication nurse and the Team Leader Nurse and given to the IDON. This process is part of our entire medication check process to assure residents are receiving medications appropriately. This process is ongoing.</p> <p>Beginning August 23, 2011 the MAR in the ECS is reviewed and compared to the current physicians' medication orders seven days a week by the RN/LPN to monitor and prevent a medication error. The results of this monitoring are reported to the IDON daily. This review/monitoring process is ongoing.</p> <p>When a resident is admitted or readmitted to the facility, the transfer plan of care recommendations from the hospital are reviewed with the attending physician by the Corporate RN Admission Coordinator or designee and</p>	

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{F 333}		{F 333}	either confirmed or revised by the attending physician. The confirmation or revision of recommendations takes place upon receipt of the orders from the transferring facility and confirmation that the resident is indeed being admitted. The confirmed admission orders are then entered into the Physicians' Orders in the ECS by the Corporate RN Admission Coordinator or designee. These orders are double checked by a RN/LPN upon admission of the resident into the facility to assure that no inconsistencies are present and that the order entry process was completed accurately and timely. This double check process continues by a RN/LPN per facility process, monitoring the MAR against the physicians' orders on a 24 hour basis, seven days a week. For residents who are readmitted, all prior physicians' orders are discontinued by the Corporate RN Admission Coordinator or designee just prior to entering all new orders into the ECS. Therefore, all physicians' orders should reflect the date of the readmission to the facility. The Administrator and/or IDON are notified of any after five pm or weekend admissions by the Corporate RN Admission Nurse, Facility Admission Nurse, Social Worker or RN Team Leader or designee to assure the appropriate		

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{F 333}		{F 333}	<p>follow up is implemented. This notification generally occurs before the resident arrives and is at a minimum within four hours after the resident has been admitted to the facility. If the Corporate RN is unavailable to initiate the usual process, the RN/LPN Team Leader enters the physician medication orders. A second RN/LPN Team Leader reviews the medication orders and matches it to the MAR. Then, a RN/LPN Medication Nurse conducts a final review matching the physicians medication orders to the MAR prior to the medications being administered. The IDON instructed the RN Team Leaders and LPN involved on this process on August 27, 2011. The Administrator or IDON reviews the process with the team to assure no medication transcription errors occur and the process is followed. This notification process began on January 16, 2011 and was revised on August 27, 2011 to assure that the order double check process could occur timely, within 24 hours from admission and the process is ongoing.</p> <p>On August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding physician order entry including alternating doses and one time only doses of medications in the FCS. as</p>		

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{F 333}		{F 333}	<p>well as lab monitoring and medication administration. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. Additionally, licensed nurses are trained on ECS during orientation by the Nurse Educator or designee. This includes how to enter physician orders. In order to assist licensed nurses, ECS reference cards were initiated on August 28, 2011. These reference cards are located on each nursing wing with instructions on how to use the ECS system. Included in this is a card on how to enter physician medication orders into the ECS system. These reference cards provide step-by-step instructions to the licensed nursing staff regarding ECS. These cards follow the one-on-one return demonstration education, which was provided by the Corporate RN and her designee and reinforces this education (see below)</p> <p>Additionally, medication pass audits are being conducted weekly on licensed nursing staff including licensed nursing agency staff by the IDON, Nurse Educator and RN Team Leaders. This audit tool was revised in April, 2011 and weekly audits began on August 8, 2011. These audits check to assure the licensed nurse identifies the resident</p>		

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B. WING \_\_\_\_\_

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R-C

09/06/2011

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IMPERIAL GARDENS HEALTH AND REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE

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MADISON, TN 37115

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prior to administering medication, and that the correct medication is given to the resident in the correct dose, by the correct route and at the right time. The monitor ensures residents who receive medications that need monitoring are reviewed or assessed prior to the administration of the medication (i.e. Digoxin, Coumadin, etc.). When applicable, lab values are checked by the RN/LPN prior to medications being given in accordance with physician orders.

A one on one in service "return demonstration for accurate order entry" was conducted with the licensed staff on 8-28 through 8-30-2011 by clinical resources outside the facility. This included the entry of a Coumadin order that required a special pattern setup, an antibiotic order, a once monthly order and an every other day order that started on a future date. The licensed nurse was observed as the orders were written, education provided when needed and checked off for competency when completed. Contract labor registered nurses and licensed nurses working in the facility during the time frame of the above listed in services also participated in the educational process.

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{F 333}			{F 333}	<p>New or returning licensed staff members including licensed agency staff will receive one-on-one education with return demonstration for accurate order entry as stated above and will be checked off for competency before working on the units by the Nurse Educator, IDON, or designee.</p> <p>On September 9, 2011 the results of audits were taken to the QI Committee. The committee determined that the Nurse Educator or designee is to continue the training with nurses (including agency nurses) on: medication pass exception report, verification of admission/readmission orders during regular hours with two licensed nurses, verification of admission/readmission orders after 5 pm or during weekends with no less than 2 licensed nurses, entering physician orders into the Electronic Charting System, and Electronic Charting System Reference Cards before working on the units. This practice will be ongoing. Additionally, the Nurse Educator or designee is to continue with medication pass audits at least twice in September and then Bi-monthly medication pass audits on all nurses (including agency) for no less than two additional months. This recommendation was approved by the QI Committee and the Administrator and is our plan for continued monitoring.</p>	